

Date: [Date]

Patient Name: [Patient Name]

Date of Birth: [Patient Date of Birth]

Medical Record Number: [MRN, if known]

Subject: Notification of Walk-Out Before Medical Evaluation Against Medical Advice (AMA)

To Whom It May Concern,

I, [Patient Name], am choosing to leave [Facility Name] at this time, [Time], on [Date]. I am leaving prior to receiving a complete medical evaluation or a formal discharge from a healthcare provider.

I acknowledge the following:

- I am leaving the facility before a physician or qualified medical professional has completed an assessment of my condition.
- I understand that by leaving now, my medical condition may worsen, and there may be undiagnosed risks, injuries, or illnesses that could lead to serious permanent disability or death.
- The staff has informed me of the potential risks of leaving without an evaluation, and I have had the opportunity to ask questions.
- I am assuming all responsibility for any physical or mental consequences resulting from my decision to leave.
- I understand that I am welcome to return to the facility at any time if I decide to seek medical care again.

By signing below, I confirm that I am leaving Against Medical Advice (AMA).

Patient/Guardian Signature

Witness Signature (Staff Member)

Date and Time